MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • Obstetrics

April 2006 • Bulletin 381

Contents

Laboratory Service Frequency Limits Clarification

Retroactive to dates of service on or after January 5, 2004, laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month via the Laboratory Services Reservation System (LSRS). Laboratory providers may use the LSRS to make reservations, or verify if a frequency limit has been reached for a specific recipient for a specific laboratory service prior to performing the procedure. When a reservation is made, the claim must be billed with the provider number used to make the reservation.

Frequency limits may be overridden on a case-by-case basis when the provider submits medical justification to support the frequency of the laboratory service for a recipient. Justification will be reviewed by medical review staff for final authorization. Providers are reminded that laboratory service claims that are denied due to frequency limitations may be appealed with submission of medical justification. Failure to make a laboratory service reservation prior to performing the laboratory service may result in denial of the claim.

The following entities are excluded from frequency limitations when the full laboratory service is rendered onsite: End Stage Renal Disease (dialysis) clinics, county public health clinics, Skilled Nursing Facilities (SNFs), inpatient hospitals and emergency rooms. The following programs are excluded from frequency limitations: California Children's Services, Genetically Handicapped Persons Program and Child Health and Disability Prevention program.

Note: Providers are reminded that independent clinical laboratories that provide services to recipients in SNFs and dialysis clinics must adhere to the same requirements to supply their claims with further documentation in support of medical justification for rendering laboratory services to these recipients.

For an overview of the LSRS process, providers can go to:
http://pro.medi-cal.ca.gov/Docs/Elearning/LSRS3028/HTML/HOME.htm

This information is reflected on manual replacement page path an over 7 (Part 2).

Recording Anesthesia Time Clarification

Providers are reminded to document time spent with a patient during obstetrical regional anesthesia in minutes as actual time spent (ACTM), not as a range of time.

Examples:

- "ACTM = 15 minutes" is acceptable documentation.
- "ACTM = 2300 – 0100" is unacceptable documentation and therefore the claim will be denied.

This updated information is reflected on manual replacement page anest 2 (Part 2).

Synagis (Palivizumab) Billing Update

Effective for dates of service on or after September 1, 2006, providers may no longer bill for Synagis (palivizumab) using local codes X7441 (Synagis 50 mg) and X7439 (Synagis 100 mg).

In accordance with the provisions of *Business and Professions Code* (B&P Code), Section 4051, Pharmacy providers who purchase and then dispense Synagis directly to a physician's office or medical clinic for administration in the medical office or clinic setting, or to a Home Health Agency (HHA) for an approved in-home visit, which may include, but not be limited to, Synagis administration, may bill Medi-Cal through the CAL-POS online system, Computer Media Claims (CMC) or paper claims using the drug's National Drug Code (NDC). The physician's office or clinic will continue to bill Medi-Cal separately for the cost of administration of Synagis. The reimbursement for the cost of Synagis administration is included in an HHA visit, so it should not be billed separately.

All claims require an approved *Treatment Authorization Request* (TAR).

- Physicians who purchase Synagis directly for administration may continue to bill with CPT-4 code 90378 (Synagis 50 mg). The administration fee is included in the reimbursement for the drug.
- Providers who meet the criteria for billing Synagis using the drug's NDC must submit TARs to either the Southern Medi-Cal Pharmacy Office by fax at 1-800-869-4325, or the Northern Medi-Cal Pharmacy Office by fax at 1-800-829-4325, as determined by the provider's geographic location.
- Physician providers billing for Synagis with CPT-4 code 90378 must continue to submit TARs to the Los Angeles Medi-Cal Field Office by fax at 1-866-816-4377.

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page cif co 2 (Part 2).

BCCTP Referral Reminder

Providers are reminded that the Breast and Cervical Cancer Treatment Program (BCCTP) offers treatment through the Medi-Cal program for individuals with breast or cervical cancer who meet the program's financial eligibility criteria. Recipients can only gain access to BCCTP through Cancer Detection Programs: Every Woman Counts primary care providers and Family PACT (Planning, Access, Care and Treatment) providers.

Diagnoses Obtained Through Cancer Detection Programs: Every Woman Counts
Women already in Cancer Detection Programs: Every Woman Counts and diagnosed with breast cancer and/or cervical cancer (including CIN II and CIN III) can be referred to BCCTP. Providers should fill in the box on the Cancer Detection Programs: Every Woman Counts breast and/or cervical data form that states, "*Patient referred to treatment,*" then follow BCCTP enrollment procedures.

Men are not eligible to enter BCCTP through Cancer Detection Programs: Every Woman Counts. They must be diagnosed by a Family PACT provider.

Diagnoses Obtained Outside Cancer Detection Programs: Every Woman Counts
Women age 25 and above who are diagnosed with cervical cancer may be enrolled into BCCTP by Cancer Detection Programs: Every Woman Counts providers. In these cases, the program provider must confirm that the woman has documentation of either breast cancer and/or cervical cancer (including CIN II and CIN III). Additionally, the provider must verify that the woman self-reports as meeting program and financial criteria for Cancer Detection Programs: Every Woman Counts by filling out the recipient eligibility form.

Providers complete the form and fill in the box that indicates the patient is being referred to BCCTP. The form may state either, "Check this box if recipient is being enrolled into Cancer Detection Program: Every Woman Counts in order to be enrolled into the Breast and Cervical Treatment Program. No Cancer Detection Program: Every Woman Count services are needed at this time" or "Recipient referred for Breast and Cervical Cancer Treatment Program (optional)". The provider must keep recipient-signed documentation of the recipient eligibility form on file. Providers then are to follow BCCTP enrollment procedures.

Providers can not bill Cancer Detection Programs: Every Woman Counts for an office visit if the only reason the recipient sees the primary care physician is for referral into BCCTP. The claim must be billed through BCCTP.

Billing Data Requirements
If a provider determines more testing is needed for a woman diagnosed outside Cancer Detection Programs: Every Woman Counts before confirming a cancer diagnosis, the provider may perform testing under the cancer program. The provider must understand that once billing occurs in Cancer Detection Programs: Every Woman Counts, the same data requirements apply as if the patient was screened within the program. This means a complete screening cycle data must be submitted on the online screening forms.

For more BCCTP information, contact the eligibility specialist at 1-800-824-0088. Additional information can be found in the Medi-Cal provider manual and at **www.medi-cal.ca.gov**.

This updated information is reflected on manual replacement pages can detect 5 thru 12 (Part 2).

Enrollment Delays for Cancer Detection Programs: Every Woman Counts

Cancer Detection Programs: Every Woman Counts providers will experience delays enrolling women in the program due to:

- Change in ownership
- Converting from a Rural Health Clinics/Federally Qualified Health Clinics (RHC/FQHC) number to a regular Medi-Cal provider number
- Change of name or address

Providers making these changes must complete the following steps in order to secure enrollment of women into Cancer Detection Programs: Every Woman Counts.

Change in Ownership or Conversions
After a change in ownership or converting between a RHC/FQHC and a regular Medi-Cal provider number, the provider is assigned a new Medi-Cal provider number. This requires a new enrollment with Cancer Detection Programs: Every Woman Counts. Providers cannot offer services until their new provider number is added to the Provider Master File (PMF) with a Cancer Detection Programs: Every Woman Counts category of service. This does not happen automatically, and takes four to six weeks. Women with immediate needs must be referred to another Cancer Detection Programs: Every Woman Counts provider.

A new Provider Enrollment Agreement (PEA) must be filed with the new provider number. Providers must contact their Regional Cancer Detection Partnership to initiate the enrollment process of their new number. Refer to section 5 in the Program Manual for Primary Care Providers which can be found on the provider support page at: **www.dhs.ca.gov/cancerdetection/providersupport.htm**.

New Provider Name or Address Change
When a new provider enrolls with Cancer Detection Programs: Every Woman Counts and the name or address on the Provider Action Form (PAF) does not coincide with the PMF, the provider must contact Licensing and Certification (for clinics or hospitals) or Provider Enrollment (for individual providers) by submitting a Medi-Cal Supplemental Application.

Providers cannot enroll until their information is changed in the PMF. For faster processing, please ensure that all paperwork submitted is complete and accurate.

Existing Provider Name or Address Change
When an existing Cancer Detection Programs: Every Woman Counts provider changes their name or address, the provider must contact Licensing and Certification (for clinics or hospitals) or Provider Enrollment (for individual providers) by submitting a Medi-Cal Supplemental Application, and submit a new PEA and *Cancer Detection Programs: Every Woman Counts, Consumer 800 number, Provider Information Survey* within 60 days of the change.

Cancer Detection Programs: Every Woman Counts Recipient Eligibility Forms Update

The two Cancer Detection Programs: Every Woman Counts recipient eligibility forms (Form A and Form B) have been replaced with a single version, available in both English and Spanish. The new versions of the *Recipient Eligibility Form* are found at the end of the *Cancer Detection Programs: Every Woman Counts* section of the appropriate Part 2 manual.

Presumptive Eligibility Program 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for Presumptive Eligibility (PE) program services for pregnant women. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table. The applicant's unborn child is counted as a member of the family; therefore, the guidelines begin with two persons (the mother and her unborn child). For specific PE questions, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

This updated information is reflected on manual replacement page presum 6 (Part 2).

Family PACT 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective for the Family PACT (Planning, Access, Care and Treatment) Program for dates of service on or after May 1, 2006. The guidelines are used to determine financial eligibility for the program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Monthly Income	Annual Income
1	$ 1,634	$ 19,600
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

CHDP 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for the Child Health and Disability Prevention (CHDP) program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart.

For additional CHDP information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	$ 1,634	$ 19,600
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

CCS/GHPP SAR Exceptions Update

Effective for dates of service on or after April 1, 2006, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers need a separate Service Authorization Request (SAR) for the following drugs, factors and nutritional products:

- Anti-Inhibitors (J7198)
- Factor VIIa Recombinant (Q0187)
- Minerals/Protein Replacements/Supplements
- Sildenafil
- Tadalafil
- Vardenafil
- Von Willebrand Factors (Q2022)

In addition, effective for dates of service on or after April 1, 2006, Factor VIIa Recombinant should be billed using HCPCS code Q0187. HCPCS code Z5230 will no longer be an active code.

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).

Upcoming Vision Care Changes in July 2006

As part of the continuing effort to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), the following vision changes will become effective for dates of services on or after July 1, 2006:

- Vision Electronic Claim Submitters:
  - Medi-Cal will **discontinue** acceptance of non-HIPAA standard electronic formats for vision claim transactions. **REGARDLESS of Date of Service**, as of July 1, 2006, the California Department of Health Services (CDHS) will no longer accept the Vision Computer Media Claim (CMC) proprietary format. Electronic claims must be billed using the HIPAA-compliant ASC X12N 837 Professional version 4010A1 format or Internet Professional Claims Submission System (IPCS).
  - ASC X12N 837 v.4010A1 Vision Companion Guide will be replaced with the ASC X12N 837 v.4010A1 Medical Companion Guide for dates of service on or after July 1, 2006. The companion guides can be found in the "HIPAA Update" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).
- **Vision Paper Claim Submitters:**
  - Paper claims must be billed on the *HCFA 1500* claim form. Medi-Cal's proprietary *Payment Request for Vision Care and Appliances* (45-1) claim form will no longer be accepted.
- **New Vision TAR Procedures:**
  - As a result of the discontinuance of the *Payment Request for Vision Care and Appliances* (45-1) claim form previously used to request prior authorization for eye appliances, a new *Treatment Authorization Request* (TAR) form (50-3) has been created for this purpose. Watch for future *Medi-Cal Updates* and announcements on the Medi-Cal Web site for details about this new form and authorization process.
- **Vision Procedural changes:**
  - Conversion of Medi-Cal Healthcare Common Procedure Coding System (HCPCS) Level III interim codes to national HCPCS Level II and Physician's Current Procedural Terminology (CPT) Level I codes.
  - Elimination of vision qualifying codes and the use of national modifiers.

Instructor-Led Seminars for Upcoming Vision Changes
Providers can access the upcoming dates and locations for Vision Seminars by visiting the Medi-Cal Web site (**www.medi-cal.ca.gov**) and clicking the "Education & Outreach" link on the left-hand navigation bar and then the "Medi-Cal Instructor-Led Seminars" link.

Self-Service HIPAA Transaction Utility Tool
A self-service environment HIPAA Transaction Utility Tool is available for submitters. The utility tool offers transaction validation (inclusive of Companion Guide-level editing); troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing; and media activation requirements. Vision electronic claim submitters have been notified via letter of utility availability, with instructions on how to use it.

Please see **Vision Care Changes**, *page 8*

Vision Care Changes *(continued)*

Electronic Attachments
New attachment submission options to expedite claims processing are available to providers or submitters. Providers now have the ability to submit fax and electronic attachments with 837 v.4010A1 electronic claim submissions. This new functionality allows providers to submit electronic claims and fax their attachments, or send the attachments electronically through an approved third-party vendor. An approved list of third-party vendors available for electronic attachment submissions will be announced in a future *Medi-Cal Update*.

In addition to faxing them, providers may also send hard copy attachments by mail. For details on how to send attachments, along with the address to mail the attachments to, please refer to the *Billing Instructions* section of the *837 Version 4010A1Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link, and then the "Billing Instructions" link.

The "837 Version 4010A1 Electronic Claims with Attachments Now Available" article published in the January 2006 *Medi-Cal Update* is also available for reference. You may access the article by clicking the "HIPAA" link on the Medi-Cal home page and then the "Electronic Transactions: Biller Updates" link.

Additional Resources
For more information, in-state providers may call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

New Vision Care Treatment Authorization Request (TAR) Process Effective July 1, 2006

Effective for vision care services performed on or after July 1, 2006, the *Payment Request For Vision Care and Appliances* (45-1) claim form will no longer be used to request prior authorization for medically necessary contact lenses, low vision aids and other non-Prison Industry Authority covered items.

Instead of the 45-1 claim form, providers will use the 50-3 *Treatment Authorization Request* (TAR) form to submit prior authorization requests for eye appliances services performed on or after July 1, 2006. A draft of this form is included with this bulletin.

The 50-3 TAR form is available and can be ordered by contacting the Telephone Service Center (TSC) at 1-800-541-5555. **However, the 50-3 TAR form cannot be used to request authorization for any service performed prior to July 1, 2006**. Please continue to follow current procedures using the 45-1 claim form to request prior authorization for dates of service prior to July 1, 2006.

New Authorization Process
The current authorization process requires that an original 45-1 claim form be mailed to the Vision Care Policy Unit (VCPU) for authorization. Effective for vision services performed on or after July 1, 2006, the 50-3 TAR form and associated documentation can be mailed or faxed to:

California Department of Health Services
Vision Care Policy Unit
MS 4600
P.O. Box 997413
Sacramento, CA 95899-7413

VCPU Fax Number: (916) 552-9077

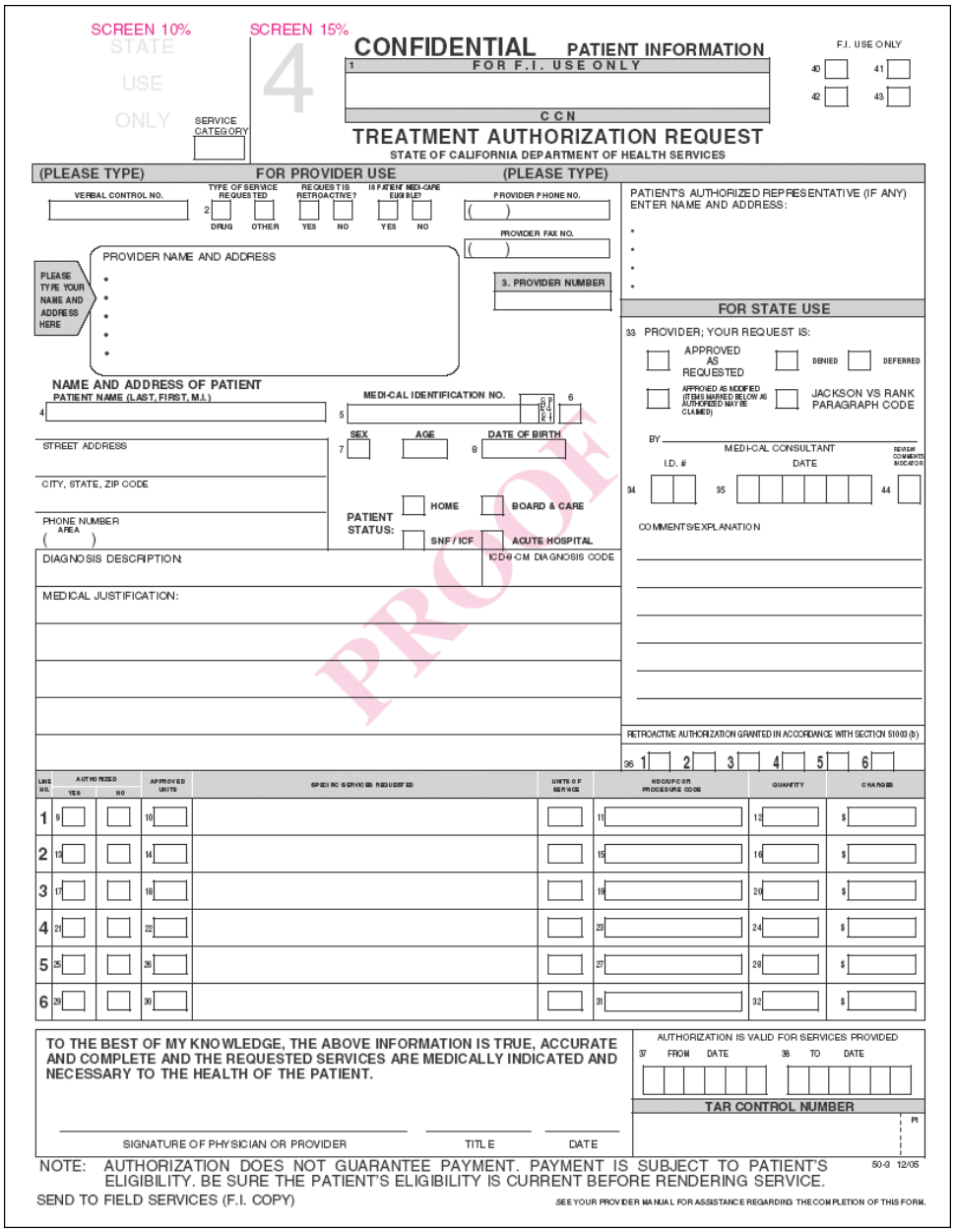
Providers should see an improved response and turnaround time for authorizations since the new TAR process allows faxed TAR submissions and responses.

Please see **TAR Process**, *page 9*

TAR Process *(continued)*

Upon completion of the authorization review process, the VCPU will fax (if a valid fax number is included on the form) or mail the 50-3 TAR form back with a decision (Approved as Requested, Approved as Modified, Denied or Deferred). All TARs are assigned a TAR Control Number (TCN) and Pricing Indicator (PI) on the 50-3 form. Claims for approved services must include a valid TCN and PI for payment. The assigned TCN and PI are also required for resubmission of deferred TARs.

Specific instructions about how to use the 50-3 TAR form and how to submit claims of approved services for payment will be addressed at Medi-Cal instructor-led seminars and future *Medi-Cal Updates*. For a schedule of upcoming seminars, please call the TSC or visit the Medi-Cal Web site at **www.medi-cal.ca.gov** and click "Education and Outreach" and then "Medi-Cal Instructor-Led Seminars."


SCREEN 10%
SCREEN 15%
STATE USE ONLY
4
CONFIDENTIAL PATIENT INFORMATION
1 FOR F.I. USE ONLY
C C N
F.I. USE ONLY
40 41 42 43
SERVICE CATEGORY
TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES
(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)
VERBAL CONTROL NO.
TYPE OF SERVICE REQUESTED 2 DRUG OTHER
REQUEST IS RETROACTIVE? YES NO
IS PATIENT MEDI-CAL ELIGIBLE? YES NO
PROVIDER PHONE NO.
PROVIDER FAX NO.
PROVIDER NAME AND ADDRESS
PLEASE TYPE YOUR NAME AND ADDRESS HERE
3. PROVIDER NUMBER
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:
FOR STATE USE
33 PROVIDER; YOUR REQUEST IS:
APPROVED AS REQUESTED
DENIED
DEFERRED
APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)
JACKSON VS RANK PARAGRAPH CODE
BY MEDI-CAL CONSULTANT I.D. # 34 DATE 35 REVIEW COMMENTS INDICATOR 44
COMMENTS/EXPLANATION
NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.) 4
MEDI-CAL IDENTIFICATION NO. 5 6
STREET ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER AREA ( )
SEX 7 AGE DATE OF BIRTH 8
PATIENT STATUS: HOME BOARD & CARE SNF / ICF ACUTE HOSPITAL
DIAGNOSIS DESCRIPTION
ICD-9-CM DIAGNOSIS CODE
MEDICAL JUSTIFICATION:
RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b) 36 1 2 3 4 5 6
LINE NO. AUTHORIZED YES NO APPROVED UNITS SPECIFIC SERVICES REQUESTED UNITS OF SERVICE HCPCS OR PROCEDURE CODE QUANTITY CHARGES
1 9 10 11 12 $
2 13 14 15 16 $
3 17 18 19 20 $
4 21 22 23 24 $
5 25 26 27 28 $
6 29 30 31 32 $
TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE
AUTHORIZATION IS VALID FOR SERVICES PROVIDED
37 FROM DATE 38 TO DATE
TAR CONTROL NUMBER PI
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.
50-3 12/05
SEND TO FIELD SERVICES (F.I. COPY)
SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.
PROOF

New *Treatment Authorization Request* (50-3) Form

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

Addition, effective April 1, 2006

Drug	**Size and/or Strength**
* ISOSORBIDE DINITRATE AND HYDRALAZINE HYDROCHLORIDE	
Tablets	20 mg – 37.5 mg
* Restricted to the treatment of heart failure as an adjunct to cardiovascular medications.	

Changes, effective April 1, 2006

Drug	**Size and/or Strength**	
AZITHROMYCIN		
* Tablets	250 mg	
* Restricted to a maximum quantity per dispensing of **eight (8)** tablets and a maximum of two (2) dispensings in any 30-day period.		
***** Tablets	500 mg	
* Restricted to a maximum quantity per dispensing of **four (4)** tablets and a maximum of two (2) dispensings in any 30-day period.		
* Tablets	600 mg	
* Restricted to use in the prevention of infections caused by Mycobacterium organisms.		
+ Powder packet	1 Gm	
* Suspension	100 mg/5cc	15 cc
	200 mg/5cc	15 cc
		22.5 cc
* Restricted to use for individuals less than eight years old with otitis media infection.		
(NDC labeler code 00069 [PFIZER INC.] only for all dosage forms and strengths of azithromycin.)		

\+ Frequency of billing requirement

Please see **Contract Drugs**, *page 11*

Contract Drugs *(continued)*

Changes, effective April 1, 2006 (continued)

Drug	**Size and/or Strength**
***** FONDAPARINUX SODIUM	
Prefilled syringe	2.5 mg
Prefilled syringe	**5 mg**
Prefilled syringe	**7.5 mg**
Prefilled syringe	**10 mg**
* Restricted to a maximum of ten (10) syringes per dispensing and a maximum of two (2) dispensings per patient in any 12-month period.	
***** LANTHANUM CARBONATE	
Tablets	250 mg
	500 mg
	750 mg
	1000 mg
***** Restricted to use in patients with end-stage renal disease.	
+ LOSARTAN AND HYDROCHLOROTHIAZIDE	
Tablets	50 mg – 12.5 mg
	100 mg – 12.5 mg
	100 mg – 25 mg

\+ Frequency of billing requirement

Instructions for Manual Replacement Pages — Part 2

April 2006

Obstetrics Bulletin 381

Remove and replace: anest 1/2
cal child sar 5/6
can detect 5 thru 12

At the end of the *Cancer Detection Programs: Every Woman Counts* section:
Remove: Recipient Eligibility Form A & B (English)
Recipient Eligibility Form A & B (Spanish)
Insert: Recipient Eligibility Form (English version)
Recipient Eligibility Form (Spanish version)

Remove: cif co 1 thru 10
Insert: cif co 1 thru 11

Remove and replace: path an over 7
preg ex hcf 11 thru 13 *
presum 5/6
tar and non cd9 1/2 *

* Pages updated due to ongoing provider manual revisions.